

043865

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 04884

1. DECEASED NAME (TYPE OR PRINT)			FIRST WILLIAM			MIDDLE E.			LAST ADKINS			2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> 2-3-87 19			2b. HOUR M						
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR May 8, 1913		6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN		7c. DATE PRONOUNCED DEAD 2-3-87 19			7d. HOUR 1 PM M						
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Florida				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Caroline County MD.									
10. CITY OR TOWN OF DEATH Easton				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Easton Memorial Hospital						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Laborer				12b. KIND OF BUSINESS OR INDUSTRY							
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						13a. STATE Maryland						13b. COUNTY Caroline		13c. CITY OR TOWN Preston		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Rt. 2, Box 221 21655			
14. FATHER'S NAME FIRST MIDDLE LAST Unknown						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unknown						16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No						16b. SOCIAL SECURITY NO. 240-48-0392		17. INFORMANT Ella Louise Cornish, Rt. 1, Box 15	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypothermia complicating alcoholism</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1																					
19a. DATE OF OPERATION						19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH						21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 2-3-87 19						21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) subject found collapsed in mud puddle									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>						21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) unknown						21f. LOCATION STREET CITY OR TOWN COUNTY STATE unknown Caroline Co., Maryland									
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																					
ACTUAL SIGNATURE Margarita A. Korell						TITLE (SPECIFY) Assistant						DATE SIGNED 2-5-87									
EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D.						ADDRESS 111 Penn Street															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial						23b. DATE Sept. 7, 1987			23c. NAME OF CEMETERY OR CREMATORY Johns Cemetery						23d. LOCATION CITY OR TOWN COUNTY STATE Preston, Caroline, Md.						
24. FUNERAL DIRECTOR NAME Frampton-Hawkins Funeral Home, 216 N. Main						ADDRESS Federalsburg, Md.						25a. DATE RECEIVED BY REGISTRAR FEB 11 1987									
25b. REGISTRAR'S SIGNATURE Julia Sanders-Randall																					

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS, AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
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late black May 2, 1913 to

U.S.A.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies of pages 1 and 2 and file them within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH-16 50M 1/81
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Kathleen		FIRST		MIDDLE		LAST Bennett		2a. DATE OF DEATH MONTH DAY YEAR 2-4-1987		2b. HOUR p	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 9-24-1911		6. AGE (IN YEARS LAST BIRTHDAY) 75		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Caroline MD.					
10. CITY OR TOWN OF DEATH Federalsburg		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 108 Greenridge Rd.						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Bookkeeping		12b. KIND OF BUSINESS OR INDUSTRY Bookkeeper	
13a. STATE Maryland		13b. COUNTY Caroline		13c. CITY OR TOWN Federalsburg		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e. STREET ADDRESS 108 Greenridge Rd. Fed., Md. 21632			
14. FATHER'S NAME FIRST MIDDLE LAST Clayton E. Covey						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Eva Satterfield					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 218-01-9565		17. INFORMANT ADDRESS Vicki Gerardi W. Central Ave. Fed., Md. 21632							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Failure DUE TO, OR AS A CONSEQUENCE OF (b) HCVD Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c) Essential hypertension APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 0 10 yrs ?											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that (I) (this hospital) attended the deceased from 4-19-1976 to 2-4-1987 , that (I) (we) last saw the deceased alive on 11-25-1985 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>H. R. Trapnell</i> MD						DEGREE MD		22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) H. R. Trapnell, M.D.						22e. ADDRESS 128 Bloomingdale Ave. Federalsburg, Md. 21632					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12-7-87		23c. NAME OF CEMETERY OR CREMATORY Hillcrest Cemetery		23d. LOCATION CITY OR TOWN Federalsburg		COUNTY Caroline		STATE Md.	
24. FUNERAL DIRECTOR NAME Williamson Funeral Home						ADDRESS Fed. Md. 21632		25a. DATE REC'D. BY REGISTRAR FEB 13 1987		25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Rodgers</i>	

MEDICAL CERTIFICATION

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove resident papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of page 4.

4441 FEB 19 1987

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										87 04 08 0 REG. NO.				
1. FOR STATE REGISTRAR					7. DECEASED NAME (TYPE OR PRINT) Bessie E. Clark					2a. DATE OF DEATH MONTH DAY YEAR 2-8-87		7b. HOUR 7:05 A.M.		
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 1 1 1902		6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Caroline MD.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Delaware		7b. CITIZEN OF WHAT COUNTRY? U.S.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Wesleyan Health Care Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Home						
10. CITY OR TOWN OF DEATH Denton					13a. STATE Md					13b. COUNTY Caroline		13c. CITY OR TOWN Greensboro		
14. FATHER'S NAME FIRST MIDDLE LAST Willard Cohee					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Maggie Clark					13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE Rt 1 Box 200 21639	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 221-24-9624		17. INFORMANT Ethel Marvel					ADDRESS Goldsboro, MD					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PNEUMONIA DUE TO, OR AS A CONSEQUENCE OF (b) SEVERE ALZHEIMER'S DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)														
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)										
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE										
22a. I certify that (I) (this hospital) attended the deceased from July 19 85, to FEB 19 87, that (I) (we) lost saw the deceased alive on 4/11/87 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE B. Grund		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>						22c. DATE SIGNED 2/9/87				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) BRUCE M. GRUND		22e. ADDRESS Box 122 GOLDSBORO, MD 21626												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 2-9-87		23c. NAME OF CEMETERY OR CREMATORY Odd Fellows Cemetery				23d. LOCATION CITY OR TOWN COUNTY STATE Camden Kent DE						
24. FUNERAL DIRECTOR NAME John E. Boulais		ADDRESS Greensboro		25a. DATE REC'D. BY REGISTRAR FEB 17 1987		25b. REGISTRAR'S SIGNATURE John Davidson-Randall								

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 04887

1 DECEASED NAME (TYPE OR PRINT)			2a. DATE KNOWN OF DEATH			2b. HOUR		
Alvin G. Crumble			Feb. 25/87			P.		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	7. DATE OF DEATH	8. DATE OF DEATH	9. DATE OF DEATH	10. DATE OF DEATH	11. DATE OF DEATH
Male	Negro	Mar. 14, 1899	87	Feb. 25, 1987	Feb. 25, 1987	Feb. 25, 1987	Feb. 25, 1987	Feb. 25, 1987
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		
Dorchester Co.			U.S.A.			Caroline		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		
Federalsburg			406 Smith Street			Laborer - Sand & Gravel Co		
13a. STATE			13b. COUNTY			13c. CITY OR TOWN		
Maryland			Caroline			Federalsburg		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			16. SOCIAL SECURITY NO.		
Elwood Crumble			Helen Augusta Smith			220-01-1606		
17a. WAS DECEASED EVER IN U.S. ARMED FORCES?			17b. SOCIAL SECURITY NO.			17c. INFORMANT		
No			220-01-1606			Helen E. Jones, Rt. 2, Box 63, Md.		
18. CAUSE OF DEATH (Enter only one cause per (a), (b), and (c).)			19. CAUSE OF DEATH (Enter only one cause per (a), (b), and (c).)			20. AUTOPSY?		
PART I DEATH WAS CAUSED BY:			PART I DEATH WAS CAUSED BY:			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
IMMEDIATE CAUSE (a)			IMMEDIATE CAUSE (a)			ACUTE MYOCARDIAL INFARCTION		
DUE TO, OR AS A CONSEQUENCE OF			DUE TO, OR AS A CONSEQUENCE OF			ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE		
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:			Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:			Chronic		
(b)			(b)					
(c)			(c)					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?		
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED		
			HOUR A.M. MONTH DAY YEAR			ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION		
						CITY OR TOWN COUNTY STATE		
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE			TITLE (SPECIFY)			DATE SIGNED		
Christian Jensen M.D.			M.D. Deputy			2/26/87		
EXAMINER'S NAME (TYPE OR PRINT)			ADDRESS			DATE SIGNED		
Christian Jensen, M.D.			RD Box 690, Denton MD 21629					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY		
Burial			Feb. 28, 1987			John's Cemetery		
23d. LOCATION			23e. DATE REC'D. BY REGISTRAR			23f. REGISTRAR'S SIGNATURE		
CITY OR TOWN COUNTY STATE			MAR 05 1987			Christian Jensen		
Preston, Caroline, Maryland								
24. FUNERAL DIRECTOR			25. DATE REC'D. BY REGISTRAR			25f. REGISTRAR'S SIGNATURE		
NAME ADDRESS			MAR 05 1987			Christian Jensen		
Frampton-Hawkins Funeral Home, 216 N. Main								

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

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07/84
25M

BP

DHMH - 17
(VR AIS ME (5))

Feb. 19/27
Feb. 19/27

Miss G. G. G. G.
Miss G. G. G. G.

Caroline
Laborer - Sand & Gravel Co.
480 South Street
Harrisburg, Pa.
Box 11, No. 11, No. 11

Nottingham Co. U.S.A.
480 South Street
Harrisburg, Pa.
Harrisburg, Pa.



Christian Jensen, Jr.
Bristol Feb. 20, 1927 John's Cemetery
Harrisburg, Pa.
Harrisburg-Hawkins Funeral Home, 210 N. Main St. No. 11

045308 FEB 26 87

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Elsie Cooper			2a. DATE OF DEATH MONTH DAY YEAR 2-22-87			2b. HOUR MIN. 8:15 A M			
3. SEX F		4. RACE N V		5. DATE OF BIRTH MONTH DAY YEAR 7 04 1897		6. AGE (IN YEARS LAST BIRTHDAY) 89 YRS.		7. IF UNDER 1 YEAR IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.	
8. BIRTHPLACE (COUNTRY) MD		9. CITIZEN OF WHAT COUNTRY? USA		10. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		11. BALTIMORE CITY OR COUNTY OF DEATH Caroline MD.			
12. CITY OR TOWN OF DEATH Denton, Md.		13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Westexan Health Care Center				14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		15. KIND OF BUSINESS OR INDUSTRY	

16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE md		13b. COUNTY Caroline		13c. CITY OR TOWN Hurlock		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE P.O. Box 816 21643	
14. FATHER'S NAME FIRST MIDDLE LAST Robert Roberts		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Alice V Hopkins		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 220-09-9331		17. INFORMANT ADDRESS Thelma P. Lyons, R.N. - Westexan Health Care Center	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>RESPIRATORY ARREST</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>PNEUMONIA</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): <u>CEREBRAL VASCULAR DISEASE, ORGANIC BRAIN SYNDROME</u>			
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19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			

22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.				22b. SIGNATURE Bruce M. Grund, MD		22c. DATE SIGNED 2/22/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Bruce M. Grund				22e. ADDRESS Box 122 GOLDSBORO, MD 21636		22f. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>	

23a. BURIAL CREMATION REMOVAL (TYPE OR PRINT)		23b. DATE 2/26/87		23c. NAME OF CEMETERY OR CREMATORY Paradise		23d. LOCATION CITY OR TOWN COUNTY STATE Trappe TA MD	
24. FUNERAL DIRECTOR (NAME)				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	

5820

043864

FOR
STATE OF
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 0488

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) James Fair			2a. DATE OF DEATH MONTH DAY YEAR 2 2 87			2b. HOUR 7 ³⁰ AM			
3. SEX MALE		4. RACE BLACK		5. DATE OF BIRTH MONTH DAY YEAR 08 26 1879		6. AGE (IN YEARS LAST BIRTHDAY) 107 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Oklahoma		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Caroline MD.			
10. CITY OR TOWN OF DEATH Denton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Caroline Nursing Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) unknown		12b. KIND OF BUSINESS OR INDUSTRY unknown	
13a. STATE Maryland				13b. CITY OR TOWN Talbot		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13d. STREET ADDRESS / ZIP CODE Unknown 21629	
14. FATHER'S NAME FIRST MIDDLE LAST unknown				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST unknown					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) unknown		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 229380075		17. INFORMANT ADDRESS Denton, Maryland 21629 K. Potter, Caroline Nursing Home,					
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) PNEUMONIA DUE TO, OR AS A CONSEQUENCE OF (b) STROKE WITH HEMIPARESIS DUE TO, OR AS A CONSEQUENCE OF (c) CEREBROVASCULAR DISEASE Chronic APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 DYS 1 MO.									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22. I certify that (I) (this hospital) attended the deceased from 19 82 to 2 Feb 19 87 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22a. SIGNATURE Christian El Jensen MD						22b. DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 2 Feb 1987	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) CHRISTIAN EL JENSEN MD						22e. ADDRESS P.O. Box 690, Denton MD 21629			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE 2/3/87		23c. NAME OF CEMETERY OR CREMATORY Delmarva Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Lewes Sussex Delaware		
24. FUNERAL DIRECTOR NAME RANDOLPH P. MOORE						25a. DATE SIGNED BY REGISTRAR FEB 11 1987		25b. REGISTRAR'S SIGNATURE John H. H. H.	

MEDICAL CERTIFICATION

BP

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. This permit, along with the death certificate, must be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, the medical examiner must be notified of a possible traumatic event, or other traumatic event, in the medical certificate.

RECEIVED - 2000 OCT 10 11:00 AM

2000 OCT 10 11:00 AM

044038 FEB 78

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

87 04890

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST William P. Guesfeird			2a. DATE OF DEATH MONTH DAY YEAR Feb. 2, 1987			2b. HOUR 7 A M	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 8 28 33		6. AGE (IN YEARS LAST BIRTHDAY) 53 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Caroline MD.	
10. CITY OR TOWN OF DEATH Greensboro		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Rt. 1 Box 382A				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Button Cutter	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland				13b. COUNTY Caroline		13c. CITY OR TOWN Greensboro	
14. FATHER'S NAME FIRST MIDDLE LAST Herman C. Guesfeird, Sr.				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Horney			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 214-28-8507		17. INFORMANT Alan Guesfeird		ADDRESS Federalsburg, MD	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a)

Chronic Obstructive Pulmonary DiseaseAPPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
YEARSConditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b) **SMOKING****YEARS**

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: **ALCOHOLISM**

MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) (this hospital) attended the deceased from DEC. 11, 1985 to SEPT. 11, 1986 , that (2) (we) lost saw the deceased alive on SEPT. 11, 1986 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death.							
22b. SIGNATURE M. Campagnolo				DEGREE MD		22c. DATE SIGNED 2-5-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) M. CAMPAGNOLO, MD				22e. ADDRESS P.O. Box 660 DENTON, MD 21629			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 2-5-87		23c. NAME OF CEMETERY OR CREMATORY Denton Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Denton CA MD	
24. FUNERAL DIRECTOR NAME John E. Boulais				ADDRESS Greensboro, MD		25a. RECEIVED BY REGISTRAR FEB 11 1987	
				25b. REGISTRAR'S SIGNATURE Julia Denson-Randall			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low required death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Their part of the certificate should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

BP

20% COMMISSION

11031 1005

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the pages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other significant event, the medical examiner, the medical examiner's assistant, or the medical examiner's assistant should be notified of this.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. DECEASED NAME (TYPE OR PRINT) Esther Nashold					2a. DATE OF DEATH MONTH DAY YEAR 02 25 87		2b. HOUR 8:55 AM		
3. SEX Female		4. RACE caucasian		5. DATE OF BIRTH MONTH DAY YEAR 05 30 1896		6. AGE (IN YEARS LAST BIRTHDAY) 90 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Caroline MD.			
10. CITY OR TOWN OF DEATH Denton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Westleyan Health Care Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Home	
13a. STATE Maryland		13b. COUNTY Caroline		13c. CITY OR TOWN Greensboro		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE Church Street 21639	
14. FATHER'S NAME FIRST MIDDLE LAST Abraham Stuff				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sarah Kaufman					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 218-09-6251		17. INFORMANT ADDRESS Thelma Lyons RN - WHCC					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) respiratory failure									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DUE TO, OR AS A CONSEQUENCE OF (b) pneumonia									
DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) organic brain syndrome coronary artery disease									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (we) lost saw the deceased alive on 2/17 , 19 87 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE J. Corwin		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 2/25/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) J. CORWIN				22e. ADDRESS P.O. Box 660 Denton MD 21629					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3-3-87		23c. NAME OF CEMETERY OR CREMATORY Greensboro Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Greensboro CA MD			
24. FUNERAL DIRECTOR NAME John E. Boulais				ADDRESS Greensboro, MD		24a. DATE REC'D. BY REGISTRAR MAR 04 1987			
				24b. REGISTRAR'S SIGNATURE Julia Anderson-Rodgers					

046481

MAR 04 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87

REG. NO.

04891

OLSON FILES

(A)

1894 40904

044720 FEB 19 1987

Item #5 G 625 3/10/87 CW

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 04892

FOR
1 - STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) CHARLES NORTH
Charles E. North

2a. DATE OF DEATH MONTH DAY YEAR 02 10 87
2b. HOUR 12 35 P.M.

3. SEX Male 4. RACE Caucasian 5. DATE OF BIRTH MONTH DAY YEAR 12 22 12
6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND 7b. CITIZEN OF WHAT COUNTRY? USA 8. MARRIED ☒ NEVER MARRIED ☐
WIDOWED ☐ DIVORCED ☐ 9. BALTIMORE CITY OR COUNTY OF DEATH Caroline MD.

10. CITY OR TOWN OF DEATH Denton 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Wesleyan Health Care Center
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) FARMER 12b. KIND OF BUSINESS OR INDUSTRY AGRICULTURE

13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE MD 13c. CITY OR TOWN DORCHESTER 13d. INSIDE CITY LIMITS? YES ☐ NO ☒ 13e. STREET ADDRESS / ZIP CODE RAILROAD AVENUE/21631

14. FATHER'S NAME FIRST MIDDLE LAST THOMAS JAMES NORTH 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY SPEDDEN

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO 16b. SOCIAL SECURITY NO. - 218-30-7120 17. INFORMANT P. O. BOX 14
HILDA M. NORTH, EAST NEW MARKET, MD 21631

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiopulmonary failure
DUE TO, OR AS A CONSEQUENCE OF (b) _____
DUE TO, OR AS A CONSEQUENCE OF (c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a Metastatic lung cancer

19a. DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED 20a. AUTOPSY? YES ☐ NO ☒ 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) 21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (1) (this hospital) attended the deceased from 12/12/86, 19_____, to 2/10/87, 19_____, that (11) (we) last saw the deceased alive on 1/15/87, 19_____, and that in (m) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.

22b. SIGNATURE J. Curwin M.D. 22c. DATE SIGNED 2/10/87
22d. PHYSICIAN'S NAME (TYPE OR PRINT) J. CURWIN 22e. ADDRESS BOX 660, DENTON, MD 21629

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL 23b. DATE 2-13-87 23c. NAME OF CEMETERY OR CREMATORY GREENLAWN CEMETERY 23d. LOCATION CITY OR TOWN COUNTY STATE CAMBRIDGE DORCHESTER MARYLAND

24a. FUNERAL DIRECTOR Zeller Funeral Home, East New Market, MD 24b. DATE REC'D. BY REGISTRAR FEB 19 1987 24c. REGISTRAR'S SIGNATURE

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return this page to the funeral director. Page 4 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or if there is any unusual event, the medical examiner should be notified at once.

BP

DHMH - 16 60M 7/84 (VRA 15, 4)

